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Healthcare Licensing and Surveys

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/09/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING ______ B. WING ______	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN CARE CENTER	2009 LARAMIE STREET TORRINGTON, WY 82240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: ADLs - activities of daily living CAA(s) - care area summary(ies) CNA - certified nursing assistant DON - director of nursing LPN- licensed practical nurse MAR(s) -medication administration record(s) MDS - Minimum Data Set mg - milligram prn - as needed RN - registered nurse Less commonly used abbreviations will be annotated in each deficiency where used.	F 000		
F 167 SS=B	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the most recent survey results were made available to residents and the public. The findings were: Observation on 7/23/12 at 5:30 PM revealed a	F 167	The facility will ensure that the most recent results of the state survey and the plan of correction. This will be accomplished by: A. The facility will post results and plan the day that the plan has been accepted by Wyoming Department of health. B. Clerical staff educated on posting the most current state survey on August 30, 2012. Clerical staff will audit following each state survey beginning with the state survey dated July 23rd – 26th and reported quarterly to QA for six months.	8/30/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — [signature] TITLE: CEO (X6) DATE: 9/7/2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This POC accepted on 9/7/12 between Mary Howe, DON and Tony Madden, Surveyor with agreed to date Ds. 9/7/12

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F 167	Continued From page 1 copy of the recertification survey dated April 2011 was posted in the lobby by the administrative offices. Interview with the administrator on 7/24/12 at 2 PM confirmed another recertification survey had been completed in December 2011 but had never been made available for resident and public review.	F 167		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of the facility's policies and procedures, the facility failed to ensure 2 of 2 residents (#68, #92) observed to self-administer medications were assessed as safe for self-administration. The findings were: 1. Observation on 7/23/12 at 3 PM showed sample resident #68 had a key around his/her neck. The resident demonstrated the key unlocked his/her bedside table which contained Pepto-Bismol. Review of the 7/20/12 physician orders showed the resident "may have Pepto-Bismol at bedside." The following concerns were identified: a. Review of the July 2012 MAR showed "Pepto-Bismol at bedside FYI [for your information]." Further review failed to show a method of tracking the frequency the medication was taken by the resident or the dose s/he	F 176	The facility will ensure that residents will not self administer medications, until the interdisciplinary team has determined that this is a safe practice. This will be accomplished by: A. Resident # 68 and #92 have had no ill effects noted from self administration of medication. "Criteria Checklist for Self Administration of Medication" has been completed on both residents on 7/26/12. Staff believe that both residents are not capable of taking his/her own medication, and are no longer administering own medications. B. "Criteria Checklist for Self Administration of Medication" form will be completed and reviewed by the interdisciplinary team prior to any resident self administering medication. C. Education to the nursing staff on : Self Administration of Medication and the "Checklist" will be completed on September 5 , 2012	9/5/12

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F 176	Continued From page 2 self-administered. b. Review of the medical record showed no evidence the resident was evaluated for self-administration of medications. In an interview on 7/26/12 at 10:25 AM, the DON stated an evaluation had not been completed prior to the resident receiving the medication at the bedside. c. Review of the "Criteria Checklist for Self-Administration of Medication" completed on 7/26/12 and received by the surveyor at 11:15 AM showed staff did not believe the resident was capable of taking his/her own medication. 2. Observation on 7/23/12 at 5:20 PM showed non-sample resident #92 had a white pill sitting next to him/her on the dining room table in the main dining area. Further observation revealed no licensed nurse was present in the area. Interview with the resident at that time showed s/he did not know the name of the medication or what the pill was for. The following concerns were identified: a. Interview on 7/24/12 at 11:45 AM with LPN #3 revealed the medication was left with the resident to take when s/he started eating. b. Review of the medical record failed to show documentation the resident had been evaluated for self-administration of medication. On 7/26/12 at 10:25 AM, the DON stated an evaluation for self-administration of medications had not been completed. c. Review of the "Criteria Checklist for Self-Administration of Medication" completed on 7/26/12 and received by the surveyor at 11:15 AM showed staff did not believe the resident was capable of taking his/her own medication. In addition, the checklist showed the resident had diagnoses to include dementia and poor vision.	F 176	D. Checklist will be completed on any resident that wishes to self administer, and will self administer medications only if appropriate. E. Goshen Care Center Nurse Managers will observe 25 medication passes monthly and reported at QA quarterly for six months.	

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F 176	Continued From page 3 3. Review of the undated policy and procedure for self-administration of medications showed the nurse was to complete the form, "Criteria Checklist for Self-Administration of Medication," to determine if the resident was eligible for self-administration. The form was then presented to the Interdisciplinary Care Team for the final decision. The result of the review was to be placed in the resident's chart.	F 176		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and family and staff interview, the facility failed to identify, assess, and care plan the use of a reclining chair as a restraint for 1 of 17 sample residents (#82). The findings were: Observation on 7/23/12 at 1:42 PM, 2:30 PM, and 4:10 PM showed resident #82 seated in a reclining chair with the feet elevated. When requested to lower the foot rest at 4:10 PM, the resident was unable to do so and became agitated when s/he could not understand or comply with the request. On 7/23/12 during an interview at 3:20 PM, a family member stated the resident was walking independently at home prior to admission in June 2012. Observation at 5:50 PM that evening showed the resident was	F 221	The facility will ensure that all residents are free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This will be accomplished by: A. Resident #82 will have a comprehensive assessment completed by September 9th, 2012. Restraints will be assessed and care planned as appropriate. B. All residents currently using a recliner will be assessed for use as possible restraint and care planned as appropriate. C. Education to nursing staff on restraint policy will be completed on September 5, 2012.	~~9/5/12~~ 9/9/12

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F 221	Continued From page 4 assisted to stand by one staff member and then ambulated with a front wheeled walker and limited assistance from the dining room to his/her room. Review of the admission MDS assessment dated 6/11/12 revealed the resident was admitted with a pelvic fracture, had severe cognitive impairment, required extensive assistance of one person with ambulation and transfer, and was not coded as using a restraint. Review of the care plan showed the recliner was not addressed as a restraint. In an interview on 7/26/12 at 8:30 AM, the MDS coordinator acknowledged the recliner should have been coded as a restraint, assessed to determine both the medical symptoms for use and if it was the least restrictive device, and care planned to minimize the potential functional decline that could result from use of a restraint.	F 221	D. Audit: Goshen Care Center Nurse Managers will audit all current residents using a recliner for use of recliner. Any new residents will be evaluated for use of recliner by MDS Coordinator.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and resident and family interview, the facility failed to provide services that would enhance the dignity of 1 of 11 sample residents (#82) dependent on staff for assistance with grooming. The findings were: Observations on 7/23/12 at 5:10 PM and 7/24/12 at 7:45 AM showed resident #82 seated in the dining room with his/her hair uncombed. On 7/25/12 at 11 AM the resident was awakened,	F 241	The facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his/her individuality by: A. Resident #82 will have her hair combed prior to meals, any social activity and PRN. B. Education to nursing staff on Dignity and respect of individuality on September 5, 2012.	9/5/12

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F 241	Continued From page 5 assisted out of the recliner, and then taken to the bathroom. The resident's hair was sticking out in the back from rubbing against the headrest of the recliner; however, CNA #8 failed to comb it prior to assisting the resident to the dining room. On 7/25/12 at 5:18 PM the resident was observed ambulating to the dining room with assistance; his/her hair was again uncombed. On 7/26/12 at 2:20 PM a family member stated the resident "would like" his/her hair combed and that it "would look better." When asked if s/he would like his/her hair combed, the resident nodded 'yes' and said "Yeah" while touching his/her hair.	F 241	C. Audit: Goshen Care Center Nurse Managers will observe 30 residents a month to ensure that hair has been combed and reported at QA quarterly for six months.	
F 257 SS=E	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interviews, the facility failed to maintain a comfortable temperature in the facility's activity/dining room. The findings were: During a confidential interview on 7/24/12 at 2 PM, 8 of 8 residents in attendance stated the activity/dining room was cold. They agreed that many residents did not like attending activities due to the temperature and the draft blowing through the room. Opening the double doors to the activity/dining room confirmed there was a considerable draft, especially when the two single doors were also open. Temperatures taken in two	F 257	The facility will provide comfortable and safe temperature levels, maintained range of 71-81 degrees. This will be accomplished by: A. Confidential resident concerns will be addressed in resident council on August 28, 2012. B. Temperature in Activity room has been increased to 73. Temperature will maintain in a range of 71-81 degrees. C. Education to all GCC staff on Federal Regulation 257—Comfortable & Safe temperature Levels to be completed by September 5th, 2012. D. Resident's will be asked on a monthly basis if the temperature of the Activity room is comfortable by activity staff.	9/5/12

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F 267	Continued From page 6 different areas of the activity/dining room at 4:48 and 5:15 PM on 7/25/12 showed an ambient temperature of 66 degrees Fahrenheit (F). The temperature in the room on 7/26/12 at 8:20 AM, confirmed by activity personnel/CNA #5, was 66 degrees F. At 9 AM that day environmental services personnel #11 stated the temperature of the room could be adjusted.	F 267	E. Audit: Weekly temperatures will be taken by Plant Ops, documented and reported at QA quarterly for six months.	
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding	F 272	The facility will conduct initial and periodical comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. This will be accomplished by: A. Resident #18, #66, #68, #72, #80, #82, #84, and #90 will have a full comprehensive assessment completed by September 9, 2012. All areas of triggered CAA will be addressed as to reflect the resident's current status. B. All current residents will have CAA reviewed to ensure accuracy, to be completed by September 30th, 2012. C. Education to all staff that input into the CAA as to completion of the assessment, by September 5, 2012. D. Audit: all completed CAA for the month will be audited for completion by MDS Coordinator and reported at QA quarterly for six months.	9/9/12

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F 272	Continued From page 7 the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and resident and staff interview, the facility failed to provide comprehensive assessments in a variety of areas for 8 of 17 sample residents (#18, #66, #68, #72, #80, #82, #84, #90). The findings were: 1. According to the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, April 2012, "Review a triggered CAA by doing an in-depth, resident-specific assessment of the triggered condition in terms of the potential need for care plan interventions...This is also an opportunity to consider any issues and/or conditions that may contribute to the triggered condition, but are not necessarily captured in the MDS data...Use the information gathered thus far to make a clear issue or problem statement." Failure to complete comprehensive assessments of triggered areas was identified as follows: a. Review of the 7/18/12 significant change MDS assessment, Section V, for resident #18 showed several areas triggered for comprehensive assessments including delirium,	F 272	This page left blank intentionally	

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F 272	Continued From page 8 cognitive loss, behaviors, and psychotropic medications. The area of the CAA to provide an analysis of the findings was lacking a description of the problem, causes and contributing factors, and risk factors for the resident. b. Review of the 6/15/12 significant change MDS assessment for resident #66 showed areas for comprehensive assessments included delirium, cognitive loss, incontinence, psychosocial well-being, mood, and behavior symptoms. The area of the CAA to provide an analysis of the findings was lacking a description of the problem, causes, and contributing factors affecting the resident. c. Review of the 6/21/12 annual MDS assessment, Section V, for resident #68 showed cognitive loss, ADLs, and mood state triggered for comprehensive assessments. The area of the CAA to provide an analysis of the findings lacked a description of the problem, causes, and contributing factors. d. During an interview on 7/26/12 at 6:10 PM resident #72 stated s/he used oxygen at night. Review of the 4/6/12 significant change and 7/5/12 quarterly MDS assessments showed the resident was not coded for use of oxygen and that a respiratory assessment was lacking. On 7/25/12 at 5:45 PM the DON verified the resident used oxygen nightly. e. According to the 6/13/12 admission MDS assessment, resident #60 triggered for comprehensive assessments in the areas of cognitive loss, visual function, ADL functional/rehabilitation potential, urinary incontinence/catheter use, psychosocial well being, mood state, behavioral symptoms, falls, and use of psychotropic medications. Review of information provided for those assessments	F 272	This page left blank intentionally	

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F 272	Continued From page 9 showed they were not comprehensive; instead of providing a critical analysis of the data, they just reiterated information in the MDS. f. Review of the 6/11/12 admission MDS assessment showed resident #82 required comprehensive assessments for cognitive loss and should have triggered for ADL functional/rehabilitation potential as s/he required extensive assistance of one staff member for all ADLs. Review of the comprehensive assessment for cognitive loss showed the facility failed to address the causes and contributing factors or identified the impacted on the resident. Detailed review of the record showed a comprehensive assessment for ADLs was lacking. On 7/25/12 during an interview at 8:30 AM, the MDS coordinator stated she was unaware the ADLs did not trigger; she confirmed comprehensive assessments should have been completed for both issues. g. Observation on 7/23/12 at 2:15 PM showed resident #84 used oxygen. According to the 2/16/12 significant change MDS assessment, the resident did not trigger for use of oxygen. However, further review of the medical record showed the resident had used oxygen for some time prior to 2/16/12, and a comprehensive assessment should have been completed. Detailed review of the record showed a comprehensive respiratory assessment and determination of the impact of continuous oxygen use on the resident was lacking. h. Review of the 3/13/12 significant change MDS assessment revealed resident #90 triggered for comprehensive assessments in the areas of communication, psychosocial wellbeing, activities, and use of psychotropic medications. Review of those assessments showed they	F 272	This page left blank intentionally	

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F 272	Continued From page 10 lacked an in-depth review of the issues and/or conditions causing and/or contributing to the problems identified in the significant change assessment. 2. Interview with the MDS coordinator on 7/26/12 at 8:30 AM confirmed comprehensive assessments had not been completed in the above described instances for residents #18, #66, #68, #72, #80, #82, #84, #90. She stated she was aware they had just been "scratching the surface" and confirmed a critical analysis of the data was lacking.	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money	F 278	The facility will ensure that assessments accurately reflect the resident's status. This will be accomplished by: A. Resident #72 and #84 will have a full comprehensive assessment completed by September 9th, 2012. Assessment will include oxygen use. B. All residents currently using oxygen will have a MDS review to ensure coded for use, completed by September 9th, 2012. C. Education for all nursing staff on accuracy of the assessment, to be completed by September 5, 2012. D. Audit: all residents with oxygen use will have a quarterly MDS audit to ensure that the assessment accurately reflects resident's current use of oxygen by MDS Coordinator . Reported at QA quarterly for six months.	9/9/12 9/5/12

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	53AD49	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN CARE CENTER	2009 LARAMIE STREET TORRINGTON, WY 82240

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F 278	Continued From page 11 penalty of not more than $6,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interview, the facility failed to ensure accurate coding on the MDS assessments for 2 of 17 sample residents (#72, #84). The findings were: 1. During an interview on 7/25/12 at 6:10 PM, resident #72 stated s/he used oxygen at night. Review of the 4/6/12 significant change and 7/5/12 quarterly MDS assessments showed the facility failed to code the resident as using oxygen. On 7/26/12 at 5:45 PM the DON verified the resident's use of oxygen. On 7/26/12 at 8:30 AM the MDS coordinator acknowledged the coding was incorrect. 2. Observation on 7/23/12 at 2:15 PM showed resident #84 used oxygen at 3 liters per minute. According to the 2/16/12 significant change MDS assessment, the resident was not coded for use of oxygen. Interview with the MDS coordinator on 7/26/12 at 8:30 AM confirmed the coding for that MDS was incorrect.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279	Tag 279 will begin on the next page	

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F 279	Continued From page 12 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to develop a comprehensive, individualized care plan that included measurable objectives and specific interventions to meet the needs for 1 of 17 sample residents (#65). The findings were: 1. An observation on 7/25/12 at 5 PM revealed resident #65 was receiving oxygen at 4 liters per minute (LPM) delivered through a nasal cannula. Review of the 7/10/12 quarterly MDS assessment showed the resident received oxygen therapy. Review of the resident's care plan for activities of daily living, last reviewed on 7/12/12, showed s/he had diagnoses to include congestive heart failure. In addition, his/her cardiac status would be maintained as evidence by no shortness of breath	F 279	The facility will ensure that each resident will have a comprehensive care plan that includes measurable objectives and timetables to meet resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. This will be accomplished by: A. Resident #65 will have a plan of care for activities of daily living to accurately reflect her current use of oxygen with liters per minute. B. Care plan updates will occur for all residents currently using oxygen with liter per minute. C. Education for all nursing staff on resident plan of care and accuracy of the care plan, to complete by September 5, 2012. D. Audit: All residents with oxygen use will have monthly care plan audit by Goshen Care Center Nurse Managers, to ensure that the care plan accurately reflects resident current use of oxygen. Reported at QA quarterly for six months.	9/5/12

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F 279	Continued From page 13 or chest pain. The care plan did not include the use of oxygen, the ordered liter flow rate, or when the resident should receive the oxygen. Interview on 7/26/12 at 8:30 AM with the MDS coordinator confirmed the use of oxygen needed to be addressed on the resident's care plan.	F 279		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and medical record review, the facility failed to ensure care plans for 6 of 17 sample residents (#18, #72, #80, #82, #83, #84) were revised to reflect each resident's current status.	F 280	The facility will ensure that each resident will have a comprehensive care plan developed within 7 days after the completion of the comprehensive assessment and periodically reviewed and revised by a team of qualified persons after each assessment. This will be accomplished by: A. Resident #18 will have his care plan updated to reflect current psychotropic drug use, specific side effects and type of behavior changes to be aware of related to the medication use. B. Resident #72 will have her care plan updated to reflect the use of oxygen and liters per minute. C. Resident #80 left for home visit on 8/11/2012, and discharged. D. Resident #82 will have her care plan updated to reflect the use of front wheeled walker and one assist. E. Resident #83 will have her care plan updated to reflect the use of oxygen, anticonvulsant and potential side effects of behavioral changes with psychotropic medication use.	

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F 280	Continued From page 14 The findings were: 1. Review of the 7/13/12 physician's order sheet and progress notes for resident #18 showed s/he was aggressive, combative, and had physically assaulted the nursing staff and other residents. Further, the resident was ordered the antipsychotics, Risperdal and Haldol, as needed for physical abuse and aggressive behavior. Review of the 7/16/12 care plan for psychotropic drug use showed the resident was to be monitored for side effects of medication use, changes in behaviors, and changes in cognitive status. The care plan did not indicate what psychotropic drugs the resident was taking, their specific side effects, or what type of behavior changes to be aware of as related to the medications. 2. During an interview on 7/25/12 at 6:10 PM, resident #72 stated s/he used oxygen at night. Review of the physician's orders verified the resident's statement. Review of the CNA daily care plan showed the resident received oxygen at night, but the flow rate in liters per minute (LPM) was not specified. Review of the interdisciplinary care plan showed oxygen was not included. Interview with the MDS coordinator on 7/26/12 at 8:30 AM confirmed the care plans needed to be revised. 3. According to the 6/13/12 admission MDS assessment, resident #80 had frequent pain that interfered with activities. Interview with the resident on 7/23/12 at 4:20 PM revealed his/her legs hurt, especially the left knee. Review of the medical record showed the resident's diagnoses included joint pain, "Enthesopathy (disorder of the	F 280	F. Resident #84 will have her care plan updated to reflect the use of oxygen and liter per minute. G. All resident care plans will be reviewed periodically and revised as needed to accurately reflect the resident's current status. All residents with use of psychotropic medication, use of walker, and use of oxygen will have care plans reviewed to ensure their care plan accurately reflects current status. H. Education to all nursing staff and MDS staff on comprehensive care plan and accuracy of care plan. I. Audit: 10 resident care plans will be audited monthly to ensure accuracy and completeness by Goshen Care Center Nurse Managers. Reported at QA quarterly for six months.	9/5/12

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F 280	Continued From page 15 muscular/tendinous attachments)" of the hip region, and bursitis. Review of the generic care plan showed the only interventions listed were: a. "Assess for pain." b. "Pain assessment quarterly and prn." c. "Medications as ordered. Refer to MAR." The care plan did not include non-pharmacological interventions, nor was it individualized or revised to meet the resident's needs. 4. Observation on 7/23/12 at 5:50 PM, 7/24/12 at 9 and 11 AM, and 7/25/12 at 5:18 PM showed resident #82 ambulated with a front wheeled walker and one assistant. Review of the 6/10/12 care plan showed an entry dated 6/19/12 indicating the resident was to ambulate with a quad (four legged) cane. Interview with the MDS coordinator on 7/26/12 at 8:30 AM revealed there was a problem with payment and the cane had not been purchased. She confirmed the care plan needed to be revised. 5. Observations on 7/23/12 at 2:20 and 3:45 PM and on 7/25/12 at 5:20 PM showed resident #83 was receiving oxygen. Review of the 6/18/12 physician's orders revealed the resident received two psychotropic medications and an anticonvulsant and that oxygen was ordered at bedtime prn. Review of the CNA and interdisciplinary care plans showed oxygen was not included. Review of the psychotropic medication care plan showed all three medications were listed as psychotropics, but the interventions did not identify potential side effects or behavioral changes for any of them. During an interview on 7/26/12 at 8:30 AM, the MDS coordinator stated the resident's behaviors were	F 280	This page left blank intentionally	

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F 280	Continued From page 16 cyclic. She confirmed oxygen was used other than at night, medication side effects, and the resident's cyclic behaviors were not identified on the care plan and the care plan needed revision. 6. Observation on 7/23/12 at 2:15 PM showed resident #84 used oxygen continuously, and an order dated 5/8/12 showed it was increased to 3 LPM per nasal cannula. Review of the interdisciplinary care plan showed oxygen was to be administered at 6 - 7 LPM per nasal cannula, but the CNA's daily care plan and the signed resident/facility contract indicated oxygen was to be at 3 - 4 LPM. On 7/26/12 at 8:30 AM the MDS coordinator was unable to explain the discrepancy. She stated oxygen could not be administered at 6 - 7 LPM per nasal cannula, and she acknowledged the care plan needed to be revised.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of medical records and policies and procedures, the facility failed to ensure professional standards of practice were maintained for 1 non-sample and 3 of 17 sample residents. This failure affected residents #79 and #84 related to medication administration and residents #5 and #65 related to failure to follow a physician's order. The findings were:	F 281	The facility will ensure that services provided or arranged will meet professional standards of quality. This will be accomplished by: A. Resident #79—no ill effect noted from ibuprofen administration. Order has been obtained for use of ibuprofen. LPN #16 has been educated on use of standing orders. B. Resident #65—no ill effect noted from increase in oxygen. Liters per minute to be maintained at 2. C. Resident # 5—Lipid panel and Depakote level drawn on July 26, 2012. Results noted and faxed to primary care	

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F 281	Continued From page 17 1. Observation on 7/23/12 at 3:12 PM showed LPN #16 administered Ibuprofen 400 mg to non-sample resident #79. During the observation, the LPN stated the medication was a standing order. Reconciliation of the medication pass revealed an order for Ibuprofen was lacking. When questioned at 4:05 PM that day, the LPN denied ever seeing a written set of standing orders. She stated she just gave medications from the bottom drawer for standing orders and tracked them on the prn and pain flow sheets. 2. During an observation on 7/25/12 at 4:16 PM, resident #65 had humidified oxygen set at 4 liters per minute (LPM) by nasal cannula. Review of the July 2012 treatment record for the resident with RN #10 on 7/25/12 at 5 PM showed oxygen was ordered to be set at 2 liters per minute. The RN acknowledged the oxygen was set at an incorrect flow rate. Further, she did not know how long it had been set at 4 LPM or who increased the rate. Review of the policy and procedure for oxygen therapy showed oxygen was a medication that required adherence to safety measures, including a physician's order and administration by a licensed healthcare provider. 3. Medical record review for resident #5 revealed physician orders for laboratory tests were written on 12/9/11 for a lipid panel and a Depakote level to be done every 6 months. Further review showed the lipid panel and Valproic Acid (same as Depakote) level were done on 12/12/11, but there were no test results for June 2012. Interview with the DON on 7/25/12 at 2:15 PM confirmed a lipid panel and Valproic Acid level had not been performed for the resident since December 2011. On 7/26/12 at 3:40 PM, the	F 281	physician. Labs to be drawn every 6 months have been added to the annual calendar to reflect accurate dates to be drawn. No ill effect noted from continued increased used of Risperdal 1.5mg for 1 month. Her primary care physician was notified of continued use on by September 5, 2012. D. Resident #84—order obtained for continuous oxygen use on 3 liter per minute on August 17th, 2012. E. Resident oxygen concentrators will be checked and documented as to appropriate liters per minute, every shift. F. All routine labs will be transcribed by the last day of the month for the following month. G. Education for nursing staff on "Standing Orders", policy and procedure for Oxygen Therapy, and policy and procedure on Gradual Dose Reduction. By September 5, 2012. H. Weekly chart checks to be performed to ensure that no orders are missed I. Audit: 1. All residents on oxygen concentrators will be audited monthly by Goshen Care Center Nurse Managers to ensure that liters per minute are as ordered and reported at QA quarterly for six months.	9/5/12 9/5/12

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F 281	Continued From page 18 administrator stated the laboratory was not involved in this error; nursing drew blood for laboratory tests and sent it, with the proper request forms, to the laboratory. Review of the January 2012 pharmacy consultant recommendation sheet for the resident showed s/he received Risperdal 1 mg each morning and 1.5 mg each evening. The pharmacist recommended a decrease in the evening dose to 1 mg. The pharmacist signed the recommendation on 1/11/12 and the physician accepted and signed the recommendation for the dose reduction on 1/12/12. Further review revealed nursing did not transcribe or note the order until 2/11/12, a month after the physician had ordered the dose reduction. Review of the resident's MARs for January and February 2012 confirmed the resident received Risperdal 1.5 mg every evening from January 12, 2012 until February 11, 2012. In an interview on 7/24/12 at 1:30 PM, the DON stated the order was "missed." 4. Observation on 7/23/12 at 2:15 PM showed resident #84 used oxygen continuously, and an order dated 5/8/12 showed it was increased to 3 LPM per nasal cannula. However, an order for oxygen was not included on the readmission orders dated 7/11/12, and there was no evidence lack of the order was clarified. According to the facility's policy and procedure, "Oxygen Therapy: Adults", effective 7/1/11, "Oxygen is a medication that requires adherence to safety measures, including physician's order..." References: According to Smith, Duell and Martin in "Clinical Nursing Skills: Basic to Advanced Skills," Seventh	F 281	2. 25 resident labs will be audited monthly by Goshen Care Center Nurse Managers to ensure transcription accuracy and reported at QA quarterly for six months. 3. All residents on oxygen will have audit to ensure that there is a physician order by Goshen Care Center Nurse Managers. Reported at QA quarterly for six months. 4. 25 charts will be audited monthly to ensure that all orders were noted at the time by Goshen Care Center Nurse Managers. Reported at QA quarterly for six months.	

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F 281	Continued From page 19 Edition, 2008; 568, "If a written order is illegible or is questionable for any reason, the physician must be notified for clarification."	F 281		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, and resident and staff interviews, the facility failed to provide appropriate monitoring and interventions for 1 of 7 sample residents (#65) and 2 non-sample residents (#41, #79) related to oxygen. In addition, the facility failed to evaluate 1 of 1 sample residents (#66) documented to have skin "bites." The findings were: 1. During a confidential interview on 7/24/12 at 2 PM two residents who used oxygen continuously stated they were required to self-propel their wheelchairs to the oxygen storage room before they could have the tanks replaced when they were empty. They further stated it was very difficult to self-propel the wheelchairs when they were "out of oxygen." An additional comment was that they would like the tanks checked before meals as it was also difficult to eat when one was not able to breathe. Observation throughout the survey showed the oxygen tanks were located on	F 309	The facility will ensure that each resident receive and provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This will be accomplished by: A. Resident concerns will be addressed at resident council on August 28, 2012. Concerns to be addressed are: residents are not required to self-propel to oxygen room to have tanks changed. If the resident notices that they are out of oxygen please ask for assistance. Staff will be documenting how much oxygen is in tank prior to meals. B. Resident #79—oxygen tank was changed, with no lasting ill effects noted. His oxygen tank will be checked and documented prior to every meal. C. Resident #41—oxygen tank was not empty, oxygen saturation was 95%. Her oxygen tank will be checked and documented prior to every meal. D. Resident #65—no ill effect noted from increase in oxygen. Liters per minute to be maintained at 2. Her	

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F 309	Continued From page 20 the back of each wheelchair and residents were unable to see the gauges to determine when the tanks were low on oxygen. 2. Observation during the evening meal on 7/25/12 showed the oxygen indicator for non-sample resident #79 registered "empty." When questioned, the resident stated s/he did not feel like there was oxygen flowing from the tank. At 5:24 PM the DON checked the tank and confirmed it was empty. The resident's oxygen saturation level taken by the DON at that time showed 85% (minimum per the standing orders was 90%). At 6:05 PM that evening the resident stated staff only checked his/her tank for oxygen when s/he told them it was empty. 3. During the evening meal on 7/25/12, observation showed the oxygen indicator for resident #41 was close to registering "empty." When requested, the DON checked the tank at 5:25 PM and confirmed it was almost empty. 4. Observation on 7/25/12 at 4:15 PM showed resident #65 had humidified oxygen set at 4 liters per minute by nasal cannula. In addition, the fluid in the humidifier was empty. Interview with RN #10 immediately after the observation revealed the humidifier needed to be replaced. Review of the resident's July 2012 treatment record with the RN on 7/25/12 at 5 PM showed oxygen was ordered to be set at 2 liters per minute. The RN acknowledged the oxygen was set at an incorrect flow rate. Further, she did not know how long it had been set at 4 liters, or who adjusted the rate. Review of the policy and procedure for oxygen therapy showed oxygen was a medication that required adherence to safety measures, including	F 309	oxygen concentrator will be checked every shift to ensure that liters per minute are as per ordered. E. Resident #66 – The RN that documented the "bites" was educated on documentation and needed notification of physician on July 27, 2012. Skin check performed on 8/16/12 by RN, primary care physician notified of area on back. F. All resident oxygen tanks will be checked and documented on prior to meals, changed if needed. G. Resident oxygen concentrators will be checked and documented as to appropriate liters per minute, every shift. H. Education to all nursing staff on policy and procedure for Oxygen Therapy by September 5, 2012. I. Weekly skin checks to be performed by nursing staff. J. Audits: 25 resident check off sheets on oxygen tanks will be audited monthly to ensure that tanks are being checked and changed when needed by Goshen Care Center Nurse Managers. Reported at QA quarterly for six months.	9/5/12

9/7/12

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	53A049	A. BUILDING _____ B. WING _____	07/26/2012

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F 309	Continued From page 21 a physician's order and administration by a licensed healthcare provider. 5. Review of the 7/20/12 nurse's notes timed at 2:30 AM showed resident #66 had "13 little bites that are scabbed over." The location of the bites was not indicated. Review of the 7/21/12 body check sheet showed the "bites" were located on the resident's mid-upper back. Further review of the nurses' notes showed no evidence additional assessments were completed or the physician was notified. Observation on 7/24/12 at 4:10 PM with graduate nurse (GN) #13 showed the resident had small pin point spots on his/her upper and lower back. Further, the resident stated his/her back itched. The GN stated she was not aware of the "bites." Interview with the DON on 7/26/12 at 11:20 AM revealed she was also unaware of the "bites." Further, she stated her expectation of the nurse who initially assessed the resident's skin was to contact the physician for further evaluation.	F 309	K. Audits: 1. All residents on oxygen concentrators will be audited monthly to ensure that liters per minute are as ordered by Goshen Care Center Nurse Managers and reported at QA quarterly for six months. 2. 25 residents will be audited for complete skin check by Goshen Care Center Nurse Managers and reported at QA quarterly for six months.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced	F 315	The facility will ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections. This will be accomplished by: A. Resident #35 had urinary analysis collected on August 14, 2012, results faxed to primary care physician, no ill effects noted from "back to front" perineal care. B. Education provided to all nursing staff on September 5, 2012 on policy and procedure "Perineal Care".	9/5/12

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F 316	Continued From page 22 by: Based on observation, medical record review, staff interview, and review of policies and procedure, the facility failed to ensure the correct procedure for perineal care was followed during 1 of 10 observations (resident #35) of perineal care. The findings were: Medical record review for resident #35 revealed a significant change MDS assessment completed on 5/18/12 showed the resident needed extensive assistance with toileting and personal care. The following concern was noted: a. Observation on 7/23/12 at 3:30 PM revealed CNA #1 was assisting the resident in the bathroom. The CNA had helped the resident remove a wet incontinence pad. While performing care, the CNA used a back to front motion to cleanse the resident's perineal area. b. Review of the facility's policy and procedure, approved on 6/1/11, revealed "Clean downward from front to back..." Interview on 7/26/12 at 9 AM with the DON revealed her expectation was that the CNAs follow the policy.	F 315	C. Audits to be 30 peri-care observations monthly by Goshen Care Center Nurse Managers and reported at QA quarterly for six months.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a	F 329	The facility will ensure that each resident drug regimen be free from unnecessary drugs. This will be accomplished by: A. Resident #5- No ill effect noted from continued increased used of Risperdal 1.5mg for 1 month. Her primary care physician was notified of continued use on August 17th, 2012. B. All residents will have pharmacy review for unnecessary drugs.	

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F 329	Continued From page 23 resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the drug regime for 1 of 20 sample residents (#5) was free of unnecessary medications. The findings were: Review of the January 2012 pharmacy consultant recommendation sheet for resident #5 showed the resident received Risperdal 1 mg each morning and, on 10/4/11, was started on 1.5 mg each evening. The pharmacist wrote the resident "...has had [increased] movements disorders resulting in Sinemet being started..." and has not displayed "...behavioral problems for several months." The pharmacist recommended the evening dose be decreased to 1 mg of Risperdal to "...decrease need for Sinemet..." and signed the recommendation on 1/11/12. The physician accepted and signed the recommendation for the dose reduction on 1/12/12. Review of the resident's MARs for January and February 2012 confirmed the	F 329	C. Education for nursing staff on policy and procedure on Gradual Dose Reduction. By September 5, 2012. D. Audit: 25 charts will be audited monthly by Goshen Care Center Nurse Managers to ensure that all orders were noted at the time. Reported at QA quarterly for six months.	9/5/12

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F 329	Continued From page 24 resident received Risperdal 1.5 mg every evening until February 11, 2012. During an interview on 7/24/12 at 1:30 PM, the DON acknowledged the order was "...missed."	F 329		
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356	The facility will ensure that nurse staffing data is posted and accurate. This will be accomplished by: A. The facility will print current staffing sheets twice daily. Changes to the staffing sheet will be made at the time a change in staffing occurs. B. Education provided to nursing staff on staffing sheets to be completed by September 5th, 2012. C. Audit: Staffing sheets will be audited weekly by Clinical Administrative Assistant to ensure accuracy and reported at QA Quarterly for six months.	9/5/12

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F 356	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on staff interview and review of staffing records, the facility failed to ensure the records accurately reflected the staff available on each shift for the past 3 months. The findings were: Observation on 7/23/12 at 5:30 PM revealed the staffing sheet for 7/23/12 was posted in the common area by the activity/dining room. Observation on 7/25/12 at 1 PM showed the posted staffing sheet was the one for 7/23/12. Interview on 7/26/12 at 9 AM with the DON revealed the afternoon charge nurse did the staffing sheet for all shifts, but she was on vacation. Review of the staffing sheets for the past 3 months revealed only one sheet had a correction on it. Further interview on 7/26/12 at 11 AM with the DON revealed she was sure staff had called in sick in the past 3 months and she confirmed the staffing sheets were probably not updated when staff called off.	F 356		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371	The facility will ensure that the food sanitation requirements are met. This will be achieved by the following. A. On Tuesday August 21st education will be provided on proper hand washing and glove use in food preparation, cleaning equipment, and utensils. B. This employee that is not using proper hand washing and glove use will be monitored on a daily basis for the first week after the education has been provided. If she is successful in her techniques she will be monitored	

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F 371	Continued From page 26 Based on observation and staff interview, the facility failed to ensure food sanitation requirements were met in a variety of areas in 1 of 3 facility kitchens. The findings were: 1. At 4:05 PM on 7/25/12 observation of the kitchen located on the secured unit showed cook #4 prepared a meal for the residents. She donned gloves and pulled apart raw chicken, then removed her gloves, and without performing hand hygiene, donned another set of gloves, and continued to cut up raw cucumbers. While wearing gloves at 5:40 PM that day, the cook adjusted the temperature on the stove, opened the refrigerator and removed the lids from containers of food. Without first removing her gloves and performing hand hygiene, the cook reached into a container of shredded cheese, removed some cheese, and placed it over the food to be served to the residents. Reference: Food Code 2009, U.S. Public Health Service, 2-301.14 When to Wash: "FOOD EMPLOYEES shall clean their hands and exposed portions of their arms...immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS...(E) After handling soiled EQUIPMENT or UTENSILS...(H) Before donning gloves for working with FOOD; and (I) After engaging in other activities that contaminate the hands." 2. Observation on 7/25/12 at 10:40 AM showed large pans were washed, rinsed and sanitized in a three compartment sink located in the main kitchen. The solution used to sanitize the	F 371	weekly until it is determined that she is following the proper glove use and hand washing techniques on a routine basis. If she is unsuccessful she will no longer be working for us. C. The quaternary ammonia chloride representative has been contacted to come and evaluate the equipment used for this product. The machine is set up in such a manner that it cannot be adjusted by anyone but the Ecolab representative. The proper ammonia level will be tracked on a filled basis and documented to ensure that the proper level is being used once the Ecolab representative corrects the issue. He was called Thursday the 26th of July and will be here to repair it on Monday the 13th of August. All dietary staff will be educated by September 9th, on proper hand washing and glove use in food preparation, cleaning equipment, and utensils D. In the event that the ammonia machine is found to be at an incorrect level, Chlorine will be used in place and tracked on the documents for chlorine use based on ppm. All dietary staff will be educated by September 9th, on proper hand washing and glove use in food preparation, cleaning equipment, and utensils	9/9/12

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F 371	Continued From page 27 equipment was "Multiquat Sanitizer 146." Dietary staff #7 tested the water used to sanitize the pans with a QAC (quaternary ammonium chloride) test strip and it showed the level to be less than 100 parts per million (ppm). Review of the product specifications showed the sanitizer was effective between 150-400 ppm. An interview with dietary staff #7 at that time confirmed the solution was not at the appropriate level for sanitizing the pans. On 7/26/12 at 10:45 AM the dietary manager reported she had performed an additional test of the sanitizer solution and found it to be too low a second time. Further, she stated the solution was checked daily but the facility did not maintain a log. Reference: 4-501.114: " A chemical sanitizer used in a sanitizing solution for a manual or mechanical operation at contact times specified under ¶ 4-703.11(C) shall meet the criteria specified under § 7-204.11 Sanitizers, Criteria, shall be used in accordance with the EPA-registered label use instructions, and shall be used as follows ... (C) A quaternary ammonium compound solution shall:(1) Have a minimum temperature of 24°C (75°F), (2) Have a concentration as specified under § 7-204.11 and as indicated by the manufacturer's use directions included in the labeling ... " 4-501.116: " Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device. "	F 371	E. The quaternary ammonia chloride temperature will continue to be tracked by the culinary staff and logged on a daily basis. F. Audit: 10 dietary staff will be observed monthly by Dietary Manager for proper hand washing and glove use in food preparation, cleaning equipment and utensils. Reported at QA quarterly for six months.	
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least	F 387	Tag F387 will begin on the next page	

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F 387	Continued From page 28 once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on medical record review and resident and staff interview, the facility failed to ensure 3 of 17 sample residents (#72, #83, #84) were seen by a physician for a face-to-face visit every 60 days as required. The findings were: 1. Review of the medical record showed no evidence resident #83 was seen by a physician from 12/21/11 until 4/5/12, a time period of 104 days. Interview with the DON on 7/26/12 at 10:30 AM revealed the physician signed orders on 2/3/12, but the facility was unable to produce evidence the resident was seen as required. 2. According to the medical record, resident #72 was not seen by a physician from 3/1/12 until 6/7/12, 97 days later. Review of information provided by the DON on 7/26/12 at 10:30 AM confirmed the dates. 3. Medical record review showed no evidence resident #84 was seen by a physician for a face-to-face visit from 1/31/12 until 4/22/12, an elapsed time of 81 days. On 7/26/12 at 10:30 AM the DON confirmed lack of evidence of a visit by the physician that met the regulatory requirements.	F 387	The facility will ensure that each resident must be seen by a physician at least once every 30 days for the firs t 90 days after admission and at least every 60 days thereafter. This will be accomplished by: A. Resident #83 has had her primary care physician notified of 104 days without physician visit by September 5, 2012 and educated on the required documentation. B. Resident #72 primary care physician notified of 97 day time period without visit. Educated on policy and requirement by September 5, 2012. C. Resident #84 primary care physician notified of 97 day time period without visit. Educated on policy and requirement by September 5, 2012. D. Resident # 72, #83, and #84 have had subsequent physician visits. E. Confidential resident concerns will be addressed in resident council on August 28, 2012. Providing residents with information related to physician visits and how to get an appointment with the physician. F. All residents that are lacking a current physician visit will have one completed by September 5, 2012. G. Education to all physicians that have residents to be completed by September 5, 2012.	9/5/12

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F 387	Continued From page 29 4. During a confidential interview on 7/24/12 at 2 PM, four of eight residents stated they seldom saw a physician. One resident stated s/he had to "get on my knees" in order to see a physician when ill recently. 5. On 7/26/12 at 1:15 PM the administrator and quality risk manager stated the facility was monitoring physician visits as they were still having trouble getting them completed as required.	F 387	H. Current Medical Director will be following up on all residents that lack a 60 physician visit. I. Audit: all physician visits to be audited monthly by Director of Nursing and reported at QA Monthly until resolved.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441	The facility will ensure there is an established and maintained infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. This will be accomplished by: A. Glucometers— Educate nursing staff to the system policy and procedure on cleaning of glucose meters as per CDC and manufacturer recommendations by September 5th, 2012. Review of SureStep Brand Meters Technical Bulletin from June 2011 B. Resident #83, #70, #54 have had no ill effects noted from possible cross contamination. C. Education provided to CNA #2 on September 7, 2012 and #6 on September 15, 2012.	~~9/15/12~~ 9/5/12

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F 441	Continued From page 30 from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of policies and procedures, the facility failed to ensure staff followed acceptable standards of practice regarding infection control practices. This failure related to cleaning the glucometer for 1 sample and 1 non-sample resident (#84, #88) and hand washing during 3 random observations (affecting residents #83, #70, #54). The findings were: 1. Observation on 7/23/12 at 4:40 PM showed LPN #16 used a glucometer to obtain the blood sugar level of sample resident #84 and then returned the glucometer to the storage container without cleaning it. At 4:50 PM that day the LPN retrieved the glucometer and, without cleaning it, approached the room of non-sample resident #88 to obtain his/her blood sugar level. Prior to entering the room, the LPN was stopped by the DON and told the glucometer was not taken into individual rooms as it would have to be cleaned each time after it was brought out. After obtaining	F 441	D. Education to all nursing staff on policy and procedure "Infection Control Guidelines" to be completed on September 5, 2012. E. Audit: 1. 30 peri-care observations to ensure proper hand hygiene monthly reported at QA quarterly. 2. Ten glucometer checks will be monitored monthly by the Infection Prevention Manager to ensure proper cleaning between resident uses. Reported at QA quarterly for six months..	9/5/12

9/7/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 31 the blood sugar results, the LPN brought the glucometer out and wiped it down with an appropriate bleach disinfectant. However, she immediately replaced the glucometer into the storage container previously used to hold the uncleansed glucometer. In addition, the LPN failed to follow the manufacturer's instructions printed on the disinfecting packet for "a 1-minute contact time" to kill many organisms; a two minute contact time was required to kill specific organisms. a. Review of the facility's policy and procedure "Cleaning of Glucose Meters," effective June 2012, showed the policy and procedure was changed "...to reflect both CDC and manufacturer recommendations for cleaning." Further review showed "Clean the external surface of the meter after every patient use...allow meter to air dry...Whenever bleach wipes are used, the cleaning must be followed by wiping with a cloth or gauze dampened with water to remove residual bleach." b. Interview with the infection control practitioner (ICP) on 7/24/12 at 4:20 PM revealed that, even though the new policy stated in bold letters "Compliance with this cleaning change begins immediately", the policy was not yet official. The ICP confirmed the policy followed current CDC guidelines. However, the policy failed to address the wet contact time required by the manufacturer. Reference: "APIC position paper: Safe injection, infusion, and medication vial practices in health care" American Journal of Infection Control, Association for Professionals in Infection Control and Epidemiology (APIC), April 2010, provides the	F 441	This page left blank intentionally	

9/7/12

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F 441	Continued From page 32 following information related to blood glucose monitoring devices: "Assign a glucometer to each individual patient if possible. Clean and disinfect glucometers if they must be shared between multiple patients. Restrict the use of finger stick capillary blood sampling devices to individual patients. Maintain supplies and equipment, such as finger stick devices and glucometers, within individual inpatient rooms, if possible. Use single-use lancets that permanently retract after puncture. Never reuse finger stick devices and lancets. Dispose of them at the point of use in an approved sharps container. Lancets in a pen should be removed by mechanical means (hemostat) to avoid finger contact. Thoroughly clean all visible soil or organic material (eg, blood) from the glucometer before disinfection. Disinfect the exterior surfaces of the glucometer after each use following the manufacturer's directions. Use an Environmental Protection Agency-registered disinfectant effective against HBV, HCV, and HIV or a 1:10 bleach solution (1 part bleach to 9 parts water). The CDC: Frequently Asked Questions (FAQs) regarding Assisted Blood Glucose Monitoring and Insulin Administration, March 8, 2011: "Whenever possible, blood glucose meters should not be shared. If they must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions. If the manufacturer does not specify how the device should be cleaned and disinfected then it should not be shared." 2. On 7/23/12 at 2:45 PM CNA #12 and training nursing assistant #14 toileted resident #83 and completed appropriate perineal care. However,	F 441	This page left blank intentionally	

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F 441	Continued From page 33 both staff members removed their gloves and completed dressing and transferring the resident, a process that involved touching the resident, his/her clothes, the sit-to-stand lift, and the wheelchair. The staff washed their hands after completing all resident care. 3. During an observation on 7/23/12 at 2:10 PM, CNA #2 donned gloves and assisted non-sample resident #70 with perineal care. While wearing the same gloves worn with perineal care, the CNA then assisted the resident to transfer from the bathroom, removed his/her shoes, and replaced the resident's oxygen cannula. 4. During an observation on 7/23/12 at 4:15 PM, CNA #6 donned gloves and preformed perineal care on non-sample resident #54. The CNA then removed her gloves, repositioned the resident, and removed the lift from the room and wiped it down before cleansing her hands. According to the facility's policy and procedure, "Infection Control Guidelines," effective 9/6/07, "When providing care/services to all patients, staff will comply with Infection Control Policies and Procedures, including, but not limited to...8. Hand Hygiene/Antisepsis." Review of the policy and procedure for hand washing, effective 10/1/10, showed indications for hand washing and/or hand antisepsis (use of antiseptic hand wash or hand rub) included "...When moving from a contaminated body site to a clean-body site during patient care...After removing gloves."	F 441	This page left blank intentionally	